STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085019	A. BUILDING _____ B. WING _____	C 02/27/2018

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COURTLAND MANOR	889 SOUTH LITTLE CREEK ROAD DOVER, DE 19901

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F 000	INITIAL COMMENTS An unannounced annual and complaint survey was conducted at this facility from February 20, 2018 through February 27, 2018. The deficiencies contained in this report are based on observations, interviews, review of residents' clinical records and review of other facility documentation as indicated. The facility census the first day of the survey was 59. The investigated sample size totaled 33 residents. Abbreviations used in this report are as follows: NHA - Nursing Home Administrator; DON - Director of Nursing; RN - Registered Nurse; LPN - Licensed Practical Nurse; MD-medical doctor; UM - Unit Manager; MDS - Minimum Data Set-standardized assessment forms used in nursing homes; NP - Nurse Practitioner; CNA - Certified Nurse's Aide; COTA - Certified Occupational Therapy Assistant; POS - Physicians Order Sheet Geri chair - high back chair that reclines; Merry Walker - Framed walker with seat; Physical Restraint - any manual method, physical or mechanical device, equipment, or material that meets all of the following criteria: o Is attached or adjacent to the resident's body; o Cannot be removed easily by the resident; and o Restricts the resident's freedom of movement or normal access to his/her body;	F 000		
F 583	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and	F 583		3/12/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 03/20/2018

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 583	Continued From page 1 confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observation it was determined that the facility failed to ensure personal privacy for 1 (R110) out of 33 sampled residents when a staff member spoke loudly at the nursing station in front of other residents stating that a resident was "incontinent" and detailed the assistance needed	F 583	A. This was an isolated incident related to the fact that R110□s caregiver is extremely hard of hearing and nursing staff must speak at a high volume for caregiver to hear and understand. The corrective action is to take this individual	

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F 583	Continued From page 2 for toileting of that resident to an inquiring care giver. Findings include: During a resident observation on 2/22/18 at 1:26 PM at the C unit nurses station, R110's caregiver came to the nurses station and asked if staff could take R110 to the bathroom. E5 RN loudly stated in the presence of several other residents present "she (R110) is a Hoyer lift (a sling type mechanical lift) she can't go to the bathroom, she is incontinent (unable to control bowel and or bladder function) and can't take herself, we have to use the machine". These findings were reviewed on 2/27/2018 at approximately 1:30 PM with E1 (NHA), E2 (DON), and E3 (Assistant Administrator), during the exit conference.	F 583	to a different area when discussing R110□s care so that others can not hear what is being said. B. At the present time no other residents were affected by the deficient practice due to the fact that this was an isolated incident involving one resident□s family member who is hard of hearing. Even though the incident was isolated, nurses will remain cognizant of other potential family members that may need to be taken to different locations to discuss care issues. C. RNs and LPNs will be in-serviced, by Nursing Administrative Staff, on being cognizant of taking family members to a different location to discuss care issues especially if those family members require the nurses to speak at a higher volume. D. Nursing Administrative Staff will continue to make random observations on all units to assure that nurses are speaking to individuals at appropriate levels or taking those individuals to different locations to discuss care issues with their loved ones. If staff is discovered to be repeating deficient practice re-education will be given.DON will report on Personal Privacy and Confidentiality at quarterly QAPI Meetings.	
F 604	Severity/Scope = 2/1 Right to be Free from Physical Restraints CFR(s): 483.10(e)(1), 483.12(a)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including:	F 604		3/20/18

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F 604	Continued From page 3 §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(2) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview it was determined that the facility failed to ensure for one (R17) out of 33 sampled residents that restraints were used only in the presence of a medical symptom and for the least amount of time and there was evidence that there was an ongoing re-evaluation of the need for a restraint. The facility failed to identify the medical symptom the restraint was being used to treat. Findings include:	F 604	A. Facility does not agree with the cited deficient practice which at most can only be deemed isolated as it only affected R17.Per discussion with Survey Team, it was discovered that facility is not documenting what is actually being done with R17. Updates to forms will be completed to allege compliance even though facility continues to disagree. B. No other residents have been affected by this cited practice but all residents will	

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F 604	Continued From page 4 The following was reviewed in R17's clinical record: 11/3/16 - Care plan last revised 7/13/17 for Restraints: Merry Walker related to gait disturbance and Blue geri chair with tray during meals related to not staying seated for meals. Interventions included: -ambulate via Merry Walker; put in geri chair with tray at meal times to promote adequate nutrition, reassess use of device every quarter and significant change to determine continuation of use or reduction of use, release device every two hours for 10 minutes for toileting and skin check and release device when spouse visits. 12/8/17 - Annual MDS documented memory problem, moderately impaired for decision making, supervision with locomotion and walking in corridor, trunk restraint and chair to prevent rising. 12/12/17 - Pre-Posture Support Device's Assessment documented "This form has been developed to adequately assess all aspects of the resident's well-being (physical, emotional, environmental and social considerations) prior to the use of either medication interventions or pre-posture support device's in order to identify the least restrictive intervention". The form indicated R17 was unsteady on feet, loses balance and history of falls. The recommendation "blue chair with tray during meals is appropriate to remain seated for meals". The assessment did not contain a medical symptom the restraint was being used for and showed no evidence that efforts had been made to discontinue or reduce the use of the restraint.	F 604	potentially, in the eyes of the survey team, benefit from the updated changes. C. Facility will complete the following 3 items: 1. A Restraint Reduction Note has been generated within the facility's electronic health record for the purpose of documenting attempts at restraint reduction. 2. Facility's Ambulation Device Assessment Form will be modified to include a section for symptoms and a narrative section. 3. Care Plans will continue to list symptoms to support the use of restraints. D. Nursing Administrative Staff will complete 1 audit per week on Care Plan, Restraint Reduction Notes and Ambulation Device Assessment Form to assure that all supporting documentation is completed. Once a success rate of 100% is achieved over a 4 week span, audits will be concluded and checks will be done during quarterly care plan meetings.	

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F 604	Continued From page 5 12/19/17 - NP note "walker wheeled uses merry walker to prevent falls". There was no mention of the tray with meals. February 2018 - POS documented tray for meals to enable her to remain rested during meals to ensure adequate nutrition and safety. (originated 9/19/17). Review of the POS lacked evidence of what medical symptom the restraint of the blue chair with tray was treating. 2/21, 2/22, 2/23 and 2/26/18 (8:00 - 4:30 PM) - R17 was observed in a blue chair with lap tray during breakfast and/or lunch. 2/26/18 2:00 PM - Interview with E8 (RN) revealed when asked if there had been attempts to trial R17 not using the tray by sitting the resident at a table with staff or spouse there was no response. 2/27/18 10:03 AM - Interview with E9 (COTA) revealed that she screens all residents quarterly but this does not involve touching the resident only observing them. E9 added that she does not assess the use of the lap tray. 2/27/18 around 9:00 AM - Interview with E1 (NHA) and E2 (DON) provided no further information on any attempt to reduce or discontinue the use of the lap tray with meals. This finding was reviewed with E1 (NHA), E2 and E3 (Assistant Administrator) at approximately 1:30 PM during exit conference on 2/27/18. Severity/Scope = 2/1	F 604		

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F 656	Continued From page 6	F 656		
F 656	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate	F 656		3/20/18

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F 656	Continued From page 7 entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview it was determined that the facility failed to ensure for one (R17) out of 33 sampled residents had an individualized care plan developed for restraint use based on the assessment and care provided. Findings include: The following was reviewed in R17's clinical record: 1/29/16 - Physical Therapy Evaluation and Plan of Treatment documented "patient uses merry walker for gait activities around the unit due to impulsiveness and history of fall. While using the merry walker, patient exhibits good safety, speed and cadence that is within functional limits for age group". 7/19/16 - Physical Therapy Discharge Summary documented "The patient has shown inconsistent progress with forward wheeled walker and showed poor motor learning in it's use. She continued to ambulate with the Merry Walker in memory care unit and due to dementia she has poor motor learning". 11/3/16 - Care plan last revised 7/13/17 for Restraints: Merry Walker related to gait disturbance and blue geri chair with tray during meals related to no staying seated for meals. Interventions included: -ambulate via Merry Walker; put in geri chair with	F 656	A. The survey team identified an issue with the care plan for R17 stating that the care plan was not individualized to reflect the disciplines that could release the Merry Walker Restraint for ambulation. Facility will update care plan to include this documentation to satisfy the cited deficient practice. B. All residents that utilize a Merry Walker have the potential to have a deficient care plan as stated above for R17. All care plans will include the appropriate documentation. C. Moving forward, Care plans will include missing documentation. Those individuals responsible for care plans were educated on including documentation that states when those departments release restrictive devices. Care Plans will be reviewed quarterly at care plan meetings and as needed. D. Corrective action will be taken as needed during reviews at the quarterly care plan meetings and as needed. Any identified need to change systems or processes will be discussed with Administration staff and placed through a QAPI PIP to determine best possible resolution.	

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F 656	Continued From page 8 tray at meal times to promote adequate nutrition, reassess use of device every quarter and significant change to determine continuation of use or reduction of use, release device every two hours for 10 minutes for toileting and skin check and release device when spouse visits. Care plan for potential for injuries related to falls, self ambulatory and wanders, adamant desire to transfer without assistance with interventions that include: -ambulate twice a day with 1 assist out of merry walker, bed alarm on bed, clothing alarm when out of bed, cow bell when in bed, falling star program (fall alert), Merry Walker when out of bed, transfer with 1 assist. Care Pan for Activities (last revised 11/18/16) included the approaches offer building walks inside and out and offer courtyard visits. 12/8/17 - Annual MDS documented memory problem, moderately impaired for decision making, supervision with locomotion and walking in corridor, trunk restraint and chair to prevent rising. February 2018 - POS documented patient to utilize Merry Walker for ambulation when out of bed, tray for meals to enable her to remain rested during meals to ensure adequate nutrition and safety. (originated 9/19/17), clothing alarm when out of bed as an alert for unsafe transfer, bed alarm on bed as an alert for unsafe transfer. 2/21, 2/22, 2/23 and 2/26/18 (8:00 - 4:30 PM) - R17 was observed throughout the dayshift ambulating in Merry Walker independently, sleeping in merry walker, ambulating with spouse	F 656		

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F 656	Continued From page 9 and aides with no Merry Walker just holding hands and in a blue chair with lap tray during meals. 2/26/18 3:13 PM - Interview with E8 (RN) revealed that activity staff do take E17 out of her Merry Walker for ambulation. 2/27/18 around 9:00 AM - Interview with E1 (NHA) and E2 (DON) about the use of the Merry Walker revealed that staff including activity staff and the family take the resident out of the Merry Walker for walks and large group activities. The care plan was not individualized to reflect the disciplines that could release the Merry Walker restraint for ambulation and when R17 could be out of the Merry Walker. This finding was reviewed with E1, E2 and E3 (Assistant Administrator) at approximately 1:30 PM during exit conference on 2/27/18. Severity/Scope = 2/1	F 656		
F 693	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was	F 693		3/12/18

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F 693	Continued From page 10 clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by: Based on observation, policy review and interview it was determined that the facility failed to follow tube feeding protocol by not labeling formula bottles for one (R6) out of 33 sampled residents. An observation was made at 2:21 PM on 02/23/18 of R6 in the dayroom. R6's formula bottle was labeled with the date, 2/23/17, the time blank was empty and AM circled. An observation was made at 11:17 AM on 02/26/18 of R6 in the dayroom. R6's formula was labeled with the date, 2/26/18, the time blank was empty and AM circled. An observation was made at 9:05 AM on 2/27/18 of R6 in his room, laying in bed. R6's formula bottle was not being fed at this time. His formula container, hanging next to the bed was still labeled 2/26/18 with the time blank empty and AM circled. The bottle's manufacturer's label directs users that the bottle is to be hung for up to 24 hours. The policy provided by the E2 (DON) is from	F 693	A. This was deemed as an isolated incident as the nurse marked the date but left the time blank on R6□s tube feed formula which goes against facility procedure. Corrective action was not immediately taken as the finding was not discussed until survey exit. See section C for corrective action. B. All residents that require tube feeding have the potential to be affected by this deficient practice but at this time no residents, outside the isolated incident regarding R6, have been affected. See section C for corrective action. C. All RNs and LPNs have been provided an in-service as a review of the proper procedure that facility follows regarding tube feed management. In-service also included the importance to assure that both date and time are marked when opening a bottle of tube feed formula. D. ADON and RNAC will complete 3 audits a week times 4 weeks to assure that all staff is following proper tube feed management as it relates to date and time of opening of formula. Once a 100% success rate achieved within 4 weeks	

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F 693	Continued From page 11 Lippincott Manual of Nursing Practice 9th ed, General Procedures and Treatment Modalities, Enteral Feeding Procedure Guidelines 20-1 and reads "use prepared dietary formulas within 24 hours." During an interview at 11:00 AM on 2/27/18, E10 (RN) verified that the time is to be written on the opened bottle of formula when it is opened. It is standard to label the bottle with the time opened. This finding was reviewed with E1 (NHA), E2 and E3 (Assistant Administrator) at approximately 1:30 PM during exit conference on 2/27/18. Severity/Scope = 2/1	F 693	nursing administrative staff will continue with random audits as needed. Findings of all audits will be reviewed with DON.	
F 732	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift.	F 732		3/12/18

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COURTLAND MANOR	889 SOUTH LITTLE CREEK ROAD DOVER, DE 19901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 732	Continued From page 12 (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined that the facility failed to post required staffing information on two (B and C) of three nursing units. Findings include: B Wing Observation 2/23/18 (10:22 AM) dry erase board at the nursing station with unit census, names of nurse and aides working day shift, the hours each employee was working was not included. C Wing Observation - 2/23/18 (10:50 AM) dry erase board at the nursing station unit census, names of nurse and aides working day shift, the hours each employee was working was not included. - 2/26/18 (10:45 AM) dry erase board included census, names of nurse and aides working day shift, the hours each employee was working was not included. It was also noted that the name of the facility was not included at the top of the dry	F 732	A. Facility does post required information on a daily basis but some of the required information was not posted during the findings documented by the survey team which is against facility practice. The corrective action is for charge nurses to check off that the staffing boards are changed each shift to assure that all required information is posted. B. No residents were affected by this deficient practice. C. All RNs and LPNs have been in-serviced on what is required to be posted and also in-serviced on whose responsibility it is to check this information every shift. D. Nursing Administrative Staff will complete 2 audits per week to assure all required information is posted. Once a success rate of 100% is achieved over a 4 week span, audits will be continued at	

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F 732	Continued From page 13 erase board like on the B Wing. During an interview with E1 (NHA) on 2/26/18 around 1:15 PM it was revealed that the facility does not post facility-wide staffing with the entire census. The information is written on each unit's dry erase board by the nursing station. E1 confirmed that the hours each staff member is working should be included on the board. These findings were reviewed with E1, E2 (DON) and E3 (Assistant Administrator) during exit conference around 1:30 PM on 2/27/18. Severity/Scope = 1/2	F 732	random.	
F 880	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following	F 880		3/20/18

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F 880	Continued From page 14 accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.	F 880		

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F 880	Continued From page 15 §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on interview and review of other facility documentation it was determined that the facility failed to conduct TB testing for 1 (E11) out of 11 sampled employees. Findings include: December 30, 2005 - Centers for Disease Control report entitled "Guidelines for Preventing the Transmission of Mycobacterium - tuberculosis[TB] in Health-Care Setting" documented: - All health-care workers should receive baseline TB screening upon hire, using two-step TB skin test or a single blood test for infection with tuberculosis. - Health-care workers working in a setting classified as low risk with a history of a positive skin test or documentation of treatment for TB disease should receive a chest x-ray to exclude TB disease (or an interpretable copy within a reasonable time frame, such as 6 months). Repeat radiographs are not needed unless symptoms or signs of TB disease develop or unless recommended by a clinician. 2/23/18 - Review of a personnel audit spreadsheet received from E3 [Assistant Administrator] discovered two staff included a chest x-ray entry for TB testing. 2/26/18 - Email response for requested dates of x-rays for the two employee found that E11 (CNA) was hired 12/21/17, chest x-ray date 2/21/14, over three years prior.	F 880	A. No residents were impacted by the cited deficient practice. See section C for corrective action. B. Potentially all residents could be affected if any individual started working who tested positive for TB. See section C for corrective action. C. For the cited deficient practice, facility was unaware that historical data was needed from previous employer. Facility obtained a copy of past chest x-ray and since it was greater then 6 months facility had employee complete a signs and symptom checklist. Process change to include any potential employee with a chest x-ray greater then 6 months will provide signs and symptoms checklist from previous employers for each year that they worked since the chest x-ray was completed. If potential employee can not reproduce this historical data and the chest x-ray is greater then 6 months, the chest x-ray must be repeated prior to starting employment. Nursing Administrative staff will oversee the new process. D. Nursing Administrative Staff will oversee the process prior to hiring and to assure that the process is being followed Nursing Administrative Staff will report at the quarterly QAPI on how many new hires had chest x-rays.	

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F 880	Continued From page 16 2/26/18 - Request from E3 to see copies of TB symptom assessment for E11 from 2015, 2016, 2017 (most likely from a previous employer). 2/27/18 - No annual TB symptom assessments were provided by the facility. Since they were not available a chest x-ray within 6 months of hire should have been completed. This finding was reviewed with E1 (NHA), E2 (DON) and E3 at approximately 1:30 PM during exit conference on 2/27/18. Severity/Scope = 2/1	F 880		

DELAWARE HEALTH AND SOCIAL SERVICES
Division of Long Term Care Residents Protection

DHSS - DLTCRP
3 Mill Road, Suite 308
Wilmington, Delaware 19806
(302) 421-7400

STATE SURVEY REPORT

NAME OF FACILITY: Courtland Manor

DATE SURVEY COMPLETED: February 27, 2018

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
3201	**The State Report incorporates by reference and also cites the findings specified in the Federal Report.** An unannounced annual and complaint survey was conducted at this facility from February 20, 2018 through February 27, 2018. The deficiencies contained in this report are based on observations, interviews, review of residents' clinical records and review of other facility documentation as indicated. The facility census the first day of the survey was 59. The investigated sample size totaled 33 residents.		
3201.1.0	**Regulations for Skilled and Intermediate Care Facilities**		
3201.1.2	**Scope** **Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.** This requirement is not met as evidenced by: Cross Refer to the CMS 2567-L survey completed February 27, 2018: F583, F604, F656, F693, F732 and F880.	Cross Reference to the CMS 2567-L survey ending 2/27/18: F583, F604, F656, F693, F732 and F880.	3/20/18

Provider's Signature Heidi A Mills Title ADMINISTRATOR Date 3/20/18